Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL342992901M
Compliance #: HL342992661C

Date Concluded: July 16, 2024

Name, Address, and County of Licensee Investigated:
River Oaks of Watertown Assisted Living
409 Jefferson Ave SW
Watertown, MN 55388
Carver County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Lena Gangestad, RN
Special Investigator

Finding: Not Substantiated

Nature of Investigation:
The Minnesota Department of Health investigated an allegation of maltreatment, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557, and to evaluate compliance with applicable licensing standards for the provider type.

Initial Investigation Allegation(s):
The facility neglected the resident when she was admitted to the hospital with bleeding from an infected pressure ulcer on her right buttock.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. While it was true the resident developed a pressure ulcer, the facility took reasonable steps to address the resident's cares.

The investigator conducted interviews with facility staff members, including nursing staff, and unlicensed staff. The investigation included review of the resident's records, staff schedules, policies, and procedures.

The resident resided in an assisted living building. The resident's diagnoses included schizoaffective disorder and type 2 diabetes. The resident's service plan included assistance of

two persons with turning and repositioning every two hours to relieve pressure. The care plan included peri-care as needed for incontinence and notified nurse with any changes in skin such as redness and breakdown.

One day, the facility found the resident did have skin breakdown and updated the physician who ordered home care. Two days later, home care assessed the wound but did not take her on because the wound did not require dressing changes to justify their services. Two weeks later, the wound healed.

A few days after the wound had healed, the resident complained of pain in the same area, so the nurse assessed the resident and found the wound had re-opened. The physician was notified, and home care was ordered again. This time home care did initiate wound care four days a week while the facility changed the dressing as needed.

The progress notes indicated during this time the resident had the flu and refused to turn from side to side to relieve pressure to the area.

Five days later, the resident was sent to the emergency room for evaluation of the right buttock wound.

During an interview, an unlicensed caregiver stated the resident had a history of refusing care. The caregiver also noted that before being hospitalized for her wound, the resident would not allow the staff to turn her on her side. Despite attempts by staff members and a nurse to reposition her, the resident insisted on lying on her back with pillows under her arm and sitting up in bed.

During an interview, the nurse stated that the resident had a wound on her buttock, and home care was primarily responsible for wound care. The nurse said the resident's cooperation with care varied depending on her mood. Although the resident was alert, oriented, and able to express her needs, she sometimes did not comply with turning schedules. The nurse said the resident initially had a smaller wound and the facility had arranged for home care services, but they did not take on her cares. She also confirmed that the resident was supposed to be turned every two hours.

In conclusion, the Minnesota Department of Health determined neglect was not substantiated.

“Not Substantiated” means:
An investigatory conclusion indicating the preponderance of evidence shows that an act meeting the definition of maltreatment did not occur.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
“Neglect” means neglect by a caregiver or self-neglect.
(a) "Caregiver neglect" means the failure or omission by a caregiver to supply a vulnerable adult

with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:
(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and
(2) which is not the result of an accident or therapeutic conduct.

Vulnerable Adult interviewed: No. The resident was deceased.
Family/Responsible Party interviewed: The resident did not have any family member.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility assessed the wound and notified provider.

Action taken by the Minnesota Department of Health:
No further action taken at this time.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34299	A. BUILDING: _____ B. WING _____	C 06/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER OAKS AT WATERTOWN	409 JEFFERSON AVENUE SW WATERTOWN, MN 55388

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments On June 3, 2024, the Minnesota Department of Health initiated an investigation of complaints #HL342992901M/HL342992661C, and #HL342991761M/HL342999527C . No correction orders are issued.	0 000		